

**U.S. Department of Labor**

Office of Administrative Law Judges  
800 K Street, NW, Suite 400-N  
Washington, DC 20001-8002

(202) 693-7300  
(202) 693-7365 (FAX)



**Issue Date: 12 May 2006**

---

In the Matter of

JIMMY R. YATES  
Claimant

Case No.: 2004 BLA 6751

v.

BLESS COAL COMPANY/  
ROCKWOOD INSURANCE CO.  
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS'  
COMPENSATION PROGRAMS  

---

Party in Interest

**DECISION AND ORDER --  
APPROVAL OF MODIFICATION REQUEST &  
DENIAL OF BENEFITS**

This matter involves a claim filed by Mr. Jimmy R. Yates for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

**Procedural Background**

Initial Claim

*Initial Adjudication*

Mr. Yates filed his first application for black lung disability benefits on August 22, 1986 (DX 1).<sup>1</sup> After a pulmonary examination, the U.S. Department of Labor ("DOL") denied the claim on December 11, 1986 because Mr. Yates failed to prove the presence of pneumoconiosis

---

<sup>1</sup>The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

and total disability. On February 6, 1987, Mr. Yates appealed. Upon consideration of additional medical evidence the Director again denied Mr. Yates' claim on January 28, 1988 due the absence of pneumoconiosis and total disability. Following Mr. Yates' February 23, 1988 appeal, the case was forwarded to the Office of Administrative Law Judges ("OALJ") on May 12, 1988.

#### *Administrative Law Judge Decision*

Administrative Law Judge Ben L. O'Brien conducted a hearing on December 5, 1988. On December 26, 1989, Judge O'Brien denied the claim because Mr. Yates did not prove the presence of pneumoconiosis or total disability. On January 3, 1990, Mr. Yates appealed the adverse decision.

#### *Benefits Review Board Decision*

On June 19, 1991, the Benefits Review Board ("BRB" and "Board") affirmed Judge O'Brien's decision denying Mr. Jewell's claim for benefits

#### Second Claim

##### *Initial Adjudication*

On September 21, 1994, Mr. Yates submitted his second claim for black lung disability benefits (DX 1). DOL denied the claim on February 6, 1995 for failure to establish the presence of pneumoconiosis and total disability. On March 15, 1995, Mr. Yates appealed and the case was forwarded to OALJ on May 23, 1995.

#### *Administrative Law Judge Decision*

Administrative Law Judge Edward J. Murty, Jr., conducted a hearing on December 7, 1995. On February 26, 1996, Judge Murty again denied Mr. Yates' claim for failure to prove the existence of pneumoconiosis and total disability. Mr. Yates appealed on March 11, 1996.

#### *Benefits Review Board Decision*

On October 17, 1996, BRB affirmed Judge Murty's denial decision.

#### Third Claim

On November 17, 1998, Mr. Yates filed his third claim for benefits (DX 2). DOL denied the claim on March 5, 1999 for failure to establish pneumoconiosis and total disability.

#### Fourth Claim

On April 11, 2001, Mr. Yates filed his fourth claim for benefits (DX 3). On May 14, 2002, DOL denied the claim because Mr. Yates failed to prove that he was totally disabled.

### Fifth Claim (Present Modification Request)

On May 13, 2003, Mr. Yates filed his fifth claim for black lung disability benefits (DX 5). DOL approved the claim on April 22, 2004 (DX 40) and the Employer appealed on June 15, 2004 (DX 45). The case was forwarded to OALJ on September 1, 2004 (DX 50). Pursuant to a Notice of Hearing, dated, November 24, 2004 (ALJ I), I conducted a hearing in Abingdon, Virginia on March 16, 2005. Mr. Yates, Mr. Wolfe, and Mr. Dickerson attended the proceedings.

### **Evidentiary Discussion**

After Mr. Yates filed his most recent claim in May 2003, the Director adjudicated the application as a subsequent claim. Likewise, at the March 2005 hearing, the parties' counsel and I addressed the proffered evidence in terms of the evidentiary restrictions contained in 20 C.F.R. § 724.414, associated with a subsequent claim. At that time, I admitted DX 1 to DX 37, DX 39 to DX 50, CX 1, EX 5, and EX 7 to EX 11. I deferred a decision on admissibility in regards to DX 38 and EX 1.<sup>2</sup>

However, as counsel for the Employer was preparing his post-hearing brief, he noted that Mr. Yates' claim was received on the day prior to the one year anniversary of the denial of his most recent prior claim (the fourth claim) which effectively rendered his May 2003 submission a modification request rather than a subsequent claim.<sup>3</sup> After a series of telephone conference calls, I determined that the claim was a modification request and directed the parties to re-designate their evidence submissions due to even greater evidentiary restrictions set out in 20 C.F.R. § 725.310 for modification proceedings. In January 2006, counsel identified their evidence in light of the 20 C.F.R. §725.310 (b) modification evidence limitations. Since Mr. Yates' claim represents a modification request, I now vacate a few of the evidentiary admission decisions that I made at the March 2005 hearing and render additional admissibility determinations.

First, based on the parties' designations, I now admit in support of their respective cases-in-chief for the modification, CX 1 and EX 7 to EX 13. Likewise, since the parties are entitled to only one rather than two pulmonary examinations and test results, I now determine that Dr. Rasmussen's January 22, 2004 pulmonary examination, DX 37, and Dr. Rosenberg's October 28, 2003 pulmonary examination, DX 33, are not admitted. Similarly, the chest x-ray interpretations associated with these pulmonary examinations, Dr. Patel's interpretation of the January 22, 2004 x-ray, DX 37, and Dr. Scatarige's interpretation of the October 28, 2003 radiographic film, DX 34, are not admitted.<sup>4</sup> Finally, since the parties' respective sets of second

---

<sup>2</sup>Employer's counsel withdrew EX 3 to EX 4, and EX 6. See footnote 4 for an explanation about EX 2.

<sup>3</sup>Mr. Yates most recent prior claim was finally denied on May 14, 2002. Although Mr. Yates dated his present claim May 17, 2003, his counsel forwarded the claim to DOL on May 6, 2003 (DX 17), and the claim was date-stamped received by DOL on May 13, 2003 (DX 5).

<sup>4</sup>The cover letter for DX 34 indicates the following three chest x-ray interpretations were being submitted: Dr. Scott's interpretation of the July 1, 2003 chest x-ray, Dr. Scatarige's interpretation of the October 28, 2003 film, and Dr. Scott's reading of a March 4, 2002 chest x-ray. However, only the first two readings are actually in the record

case-in-chief chest x-rays are not admissible, the rebuttal interpretation of Dr. Wheeler for the January 22, 2004 film, EX 5, is not admitted.

Second, at the hearing, Claimant's counsel offered as rebuttal an interpretation by Dr. Alexander of the July 1, 2003 film produced during the DOL pulmonary examination, DX 38 (TR, page 12 to 19). Although Dr. Alexander found the film positive for pneumoconiosis, which was the same result Dr. Patel reached, counsel asserted that Dr. Alexander's comments about different opacities, exposure, and preliminary profusion represented rebuttal to Dr. Patel's positive chest x-ray reading. I deferred a determination in the hope subsequent case law might address whether "rebuttal" under the regulations means "different" or "opposite." To date, no appellate guidance has been provided. However, based on the construction of the regulatory limitations in terms of case-in-chief and rebuttal, I conclude the term "rebuttal" means contrary or opposite. Since Dr. Alexander's positive interpretation did not refute Dr. Patel's positive determination, I conclude it is not rebuttal and thus DX 38 is not admissible.

Third, in the event that I determine Dr. Alexander's interpretation of the July 1, 2003 chest x-ray was admissible, Employer's offered an interpretation by Dr. Wheeler of the July 1, 2003 film, EX 1, as a rebuttal (TR pages 25 to 26). Since I have excluded Dr. Alexander's interpretation of this film, Dr. Wheeler's rebuttal interpretation, EX 1, is also not admitted.

Fourth, based on the change in nature of Mr. Yates' claim from a subsequent claim to a modification request, I must also address the admissibility of the DOL-sponsored July 1, 2003 pulmonary examination by Dr. Rasmussen. Counsel for the Employer has asserted that since Mr. Yates' claim was actually a modification request, the DOL-sponsored examination should never have been administered and thus is not admissible.

Of course, the regulatory evidentiary restrictions do not directly address this situation. Clearly, under 20 C.F.R. § 725.310 (b), during modification proceedings, the "claimant" and "operator," and "fund as appropriate" are each limited to the submission of "no more than one additional chest X-ray interpretation, one additional pulmonary function test, one additional arterial blood gas study, and one additional medical report in support of its affirmative case" and otherwise permissible rebuttal evidence. However, since a named operator is litigating this case, the "fund" is not an active litigant such that the modification evidence limits do not apply to the DOL-sponsored examination. Consequently, although DOL is not required to provide another pulmonary examination during the modification process, if such an examination is nevertheless conducted, the modification evidentiary limitations do not specifically exclude it. Accordingly, the DOL-sponsored pulmonary examination by Dr. Rasmussen on July 1, 2003 and the associated chest x-ray by Dr. Patel, DX 12 to DX 16, will remain in the record.

---

as DX 34; Dr. Scott's January 2004 interpretation of the March 4, 2002 film is not included. Similarly, pre-hearing, Employer's counsel designated Dr. Scott's evaluation of the March 4, 2002 chest x-ray as EX 2; however, at the hearing, he did not offer EX 2. As a possible explanation, I note that during the consideration of the fourth claim, Dr. Halbert interpreted the March 4, 2002 chest x-ray as positive for pneumoconiosis. However, the Employer did not obtain a rebuttal interpretation by Dr. Scott until January 2004, well after the May 2002 denial of the fourth claim.

Correspondingly, and fifth, I must address rebuttal evidence to the DOL-sponsored examination. In the his first pre-hearing statement, when Employer's counsel believed the proceedings involved a subsequent claim, he designated as sole rebuttal to the exam an interpretation by Dr. Scott of the July 1, 2003 chest x-ray. That interpretation, contained in DX 34, is admitted.

Sixth, since the final evidentiary admissibility determinations are only now just being made, many of the physicians who evaluated Mr. Yates' pulmonary condition have reviewed medical evidence that is no longer admissible. That presents another confounding procedural problem since under 20 C.F.R. §§ 725.414 (a) (2) (i) and 3 (i) "any chest X-ray interpretation, pulmonary function test results, blood gas studies . . . and physician opinions that appear in a medical report must each be admissible . . ." under the regulations. In *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1- \_\_\_, BRB No. 04-0812 BLA (Jan. 27, 2006) (en banc), when confronted with a medical opinion that contained evidence not admitted into the formal record, the Benefits Review Board indicated that an administrative law judge may: a) exclude the report; b) redact the objectionable content; c) require a revised report; or, d) consider the physician's reliance on the inadmissible evidence in deciding the probative value of the report. In the present case, I will apply a combination of the second and fourth options. I will not use the objectionable content and I will consider probative value based in part the extent to which a medical expert relied upon inadmissible evidence.

And at last, seventh, I left the record open at the close of the hearing to give the Employer an opportunity to respond to Dr. Forehand's February 2005 pulmonary examination (TR, page 54). I have subsequently received Dr. Wheeler's interpretation of a February 4, 2005 chest x-ray and April 18, 2005 comments by Dr. Castle, which I now admit as EX 12 and EX 13.

In summary, based on the interminable evidentiary rulings above, my decision in this case is based on the hearing testimony and the evidence I have now admitted into evidence: DX 1 to DX 32, portion of DX 34, DX 35, DX 36, DX 39 to DX 50, CX 1, EX 7 to EX 13.

## ISSUES

1. Whether in filing a modification request on May 13, 2003, Mr. Yates has demonstrated that either: a) a change has occurred in one of the conditions, or elements, of entitlement upon which the denial of his fourth claim was based; or, b) a mistake in determination of fact occurred in Director's denial of his most recent prior claim on May 14, 2002.
2. If Mr. Yates establishes a change in one of the applicable conditions of entitlement or a mistake in determination of fact, whether he is entitled to benefits under the Act.

## **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

### **Stipulations of Fact**

At the March 16, 2005 hearing, the parties stipulated: a) Mr. Yates had at least 21 years of coal mine employment; b) Mr. Yates was a post-1969 coal miner; c) Mrs. Linda Yates is a dependent for the purposes of augmenting any benefits that may be payable under the Act; and, d) Bless Coal Company is the responsible operator (TR, pages 7 to 9).

### **Preliminary Findings**

Born on December 13, 1943, Mr. Yates married Mrs. Linda Yates on April 1, 1969. Mr. Yates started mining coal in truck mines in the early 1960s. In 1988, he was pulled out of the mines due to his lungs. In his last job as a coal miner, Mr. Yates was a pinner operator/roof bolter. Part of his job required him to lift and carry rock dust bags, weighing up to 50 pounds. In his opinion, his work as a pinner operator involved “hard dead” physical labor. Mr. Yates continues to struggle with chronic shortness of breath and smothering. He started smoking cigarettes regularly in his 20s and stopped in 1997. For most of that period, Mr. Yates was smoking a pack to a pack and a half of cigarettes a day (DX 1, DX 5 to DX 8, and TR, pages, 32 to 51).

### **Issue # 1 – Modification**

Any party to a proceeding may request modification at any time before one year from the date of the last payment of benefits or at any time before one year after the denial of a claim. 20 C.F.R. § 725.310 (a). Upon the showing of a "change in conditions" or a "mistake in a determination of fact" the terms of an award or the decision to deny benefits may be reconsidered. 20 C.F.R. § 725.310. An order issued at the conclusion of a modification proceeding may terminate, continue, reinstate, increase or decrease benefit payments or award benefits.

According to the courts and BRB, the phrase “change in conditions” refers to a change in a claimant’s physical condition. See *General Dynamics Corp. v. Director, OWCP*, 673 F.2d 23 (1st Cir. 1982) and *Lukman v. Director, OWCP*, 11 B.L.R. 1-71 (1988) (*Lukman II*). Under the regulatory provisions, to determine whether a claimant demonstrates a change in conditions, an administrative law judge (“ALJ”) must first conduct an independent assessment of all newly submitted evidence. Then, the ALJ must consider this new evidence in conjunction with all evidence in the official U.S. Department of Labor record to determine if the weight of the evidence is sufficient to establish an element of entitlement which was previously adjudicated against the claimant. *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994); *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993); *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), *aff’d. on reconsideration*, 16 B.L.R. 1-71 (1992).

The modification process has been further expanded by the United States Supreme Court and federal Courts of Appeals when they considered cases involving the mistake of fact factor

listed in the regulations. In *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971), the United States Supreme Court indicated that an ALJ should review all evidence of record to determine if the original decision contained a mistake in a determination of fact. In considering a motion for modification, the ALJ is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." See also *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993); *Director, OWCP v. Drummond Coal Co. (Cornelius)*, 831 F.2d 240 (11th Cir. 1987).

My determination of whether either a change in condition has developed or a mistake of fact occurred involves the four entitlement elements that a claimant must prove by a preponderance of the evidence to receive benefits under the Act. First, the coal miner must establish the presence of pneumoconiosis.<sup>5</sup> Second, if a determination has been made that a coal miner has pneumoconiosis, it must be determined whether the coal miner's pneumoconiosis arose, at least in part, out of coal mine employment.<sup>6</sup> If a coal miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.<sup>7</sup> Otherwise, the claimant must provide competent evidence to establish the relationship between pneumoconiosis and coal mine employment.<sup>8</sup> Third, the coal miner must demonstrate total respiratory disability.<sup>9</sup> Fourth, the coal miner must prove the total disability is due to coal workers' pneumoconiosis.<sup>10</sup>

Upon adjudication of Mr. Yates' fourth claim, DOL denied benefits because Mr. Yates did not establish the presence of a totally disabling pulmonary impairment. In light of that finding, I will first evaluate whether Mr. Yates is able to demonstrate a change of conditions through new evidence developed since the record closed in the spring of 2002 by showing he has since become totally disabled due to a pulmonary impairment. Secondly, if necessary, I will consider the entire evidentiary record to determine whether a mistake of fact has occurred in the May 2002 determination that Mr. Yates was not totally disabled.

#### Change in Condition

Under the change of conditions analysis, I must examine the medical evidence developed since 2002 to determine whether Mr. Yates has developed a pulmonary impairment that is totally disabling. In that regard, to receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner

---

<sup>5</sup>20 C.F.R. §718.202.

<sup>6</sup>20 C.F.R. §718.203 (a).

<sup>7</sup>20 C.F.R. §718.203 (b).

<sup>8</sup>20 C.F.R. §718.203 (c).

<sup>9</sup>20 C.F.R. §718.204 (a).

<sup>10</sup>*Id.*

suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir.*, OWCP, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

The record does not contain sufficient evidence that Mr. Yates has complicated pneumoconiosis and he has not presented evidence of cor pulmonale with right-sided congestive heart failure. As a result, Mr. Yates must demonstrate total respiratory or pulmonary disability through arterial blood gas studies, pulmonary function tests, or medical opinion.

#### Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO <sup>2</sup> (rest) pCO <sup>2</sup> (exercise)	pO <sup>2</sup> (rest) pO <sup>2</sup> (exercise)	Qualified <sup>11</sup>	Comments
DX 11 & 12	July 1, 2003 Dr. Rasmussen	32	72	No <sup>12</sup>	Slight impairment at rest; marked impairment with slight exercise.
		33	59	Yes <sup>13</sup>	
EX 7	Jun. 23, 2004 Dr. Castle <sup>14</sup>	37	70	No <sup>15</sup>	Normal
CX 1	Feb. 4, 2005 Dr. Forehand	31	73	No <sup>16</sup>	Exercised-induced hypoxemia.
		33	59	Yes	

<sup>11</sup>To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO<sup>2</sup> level, the value of the coal miner's pO<sup>2</sup> must be equal to or less than corresponding pO<sup>2</sup> value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. Part 718.

<sup>12</sup>For the pCO<sup>2</sup> of 32, the qualifying pO<sup>2</sup> is 68, or less.

<sup>13</sup>For the pCO<sup>2</sup> of 33, the qualifying pO<sup>2</sup> is 67, or less.

<sup>14</sup>Although Mr. Yates testified that he was willing to undergo an exercise blood gas study, Dr. Castle did not conduct the procedure due to an "abnormal electrocardiogram and symptoms consistent with ongoing angina pectoris."

<sup>15</sup>For the pCO<sup>2</sup> of 37, the qualifying pO<sup>2</sup> is 63, or less.

<sup>16</sup>For the pCO<sup>2</sup> of 31, the qualifying pO<sup>2</sup> is 69, or less.



The preponderance (3 out of 5) of the arterial blood gas tests do not meet the total disability threshold. However, significantly, the two tests of Mr. Yates' oxygen transfer capacity during exercise showed a significant impairment that passes the total disability standard. According to Mr. Yates' credible testimony, his last job as a coal mine pinner operator required heavy labor associated in part with the transportation of rock dust bags. Since the exercise arterial blood gas studies satisfy the regulatory total disability requirements and clearly demonstrate Mr. Yates is no longer capable of accomplishing heavy labor, I find Mr. Yates has established total disability under 20 C.F.R. § 718.204 (b) (2) (ii).

Correspondingly, based on the exercise arterial blood gas studies developed since 2001, Mr. Edwards has shown a change in conditions by establishing he has become totally disabled due to a pulmonary impairment. As a result, the finding in the 2002 denial of his fourth claim that Mr. Yates does not have a totally disabling pulmonary impairment may be modified. Although the evidence in 2001 did not show total disability, I note that since pneumoconiosis is defined as a "latent and progressive" disease under 20 C.F.R. § 718.201 (c), the most recent arterial blood gas studies are more probative on whether Mr. Yates is now totally disabled. Thus, because the two most recent exercise blood gas studies show that Mr. Yates no longer has the oxygen transfer capability necessary for his last job as a pinner operator, modification of the May 2002 determination that he was not totally disabled is hereby modified – I find Mr. Yates has a totally disabling pulmonary impairment.

In turn, since Mr. Yates' fourth claim for benefits in 2002 was a subsequent claim, and his third claim in 1998 was denied in part due to the failure to establish total disability, Mr. Yates has now also established an element of entitlement previously adjudicated against him. As a result, under the provisions in 20 C.F.R. § 725.309, I will review the entire record to determine whether Mr. Yates is able to prove all four elements necessary for entitlement of benefits under the Act; thereby establishing that he is totally disabled due to coal workers' pneumoconiosis. During this process, according to 20 C.F.R. § 725.309 (4) no finding made in prior claims, except those based on a party's failure to contest the issue, shall be binding on the parties.

## **Issue # 2 – Entitlement to Benefits**

Again, to establish entitlement to black lung disability benefits under Act, Mr. Yates must prove: a) the presence of pneumoconiosis; b) pneumoconiosis related to coal mine employment; c) total pulmonary disability; and, d) total disability due to coal workers' pneumoconiosis.

### Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.<sup>17</sup> The regulatory definitions include both clinical or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."<sup>18</sup>

---

<sup>17</sup>20 C.F.R. § 718.201 (a).

<sup>18</sup>20 C.F.R. §§ 718.201 (a)(1) and (2).

The regulation further indicates that a lung disease arising out of coal mine employment includes “any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.”<sup>19</sup> As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),<sup>20</sup> and medical opinion (§ 718.202 (a)(4)). Since the record does not contain sufficient evidence that Mr. Yates has complicated pneumoconiosis,<sup>21</sup> and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. In addition, he has not submitted a biopsy report and the record obviously does not contain an autopsy report. As a result, Mr. Yates will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis. Additionally, under the guidance of *Compton*,<sup>22</sup> I must consider the chest x-ray evidence and medical opinion together to determine whether a claimant can establish pneumoconiosis.

### *Chest X-Rays*

The following table summarizes all chest x-ray interpretations admitted into evidence:

Date of x-ray	Exhibit	Physician	Interpretation
Mar. 19, 1973	DX 1	Dr. Sutter	Positive for pneumoconiosis, profusion category 1/2, <sup>23</sup> type p opacities. <sup>24</sup>

<sup>19</sup> 20 C.F.R. § 718 (b).

<sup>20</sup> If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

<sup>21</sup> In his interpretation of the May 3, 2004 chest x-ray, Dr. Scatarige identified a possible “1.5 nodular density” for further evaluation. However, Dr. Scatarige did not use any measurement standard, such as millimeter or centimeter, and none of the other multiple chest x-ray interpretations contained a finding of complicated pneumoconiosis.

<sup>22</sup> See *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

<sup>23</sup> The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102 (b), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

(same)	DX 1	Dr. Pendergrass, BCR, B <sup>25</sup>	Completely negative.
(same)	DX 1	Dr. Wiot, BCR, B	Completely negative.
(same)	DX 1	Dr. Wheeler, BCR, B	Completely negative.
Oct. 4, 1985	DX 1	Dr. Modi	Positive for pneumoconiosis, profusion category 1/2, type p/q opacities.
Nov. 26, 1986	DX 1	Dr. Navani, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type p opacities.
(same)	DX 1	Dr. Gaziano, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type t opacities.
(same)	DX 1	Dr. Binns, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type p/s opacities.
(same)	DX 1	Dr. Gogineni, BCR, B	Completely negative.
Jul. 30, 1987 <sup>26</sup>	DX 1	Dr. Robinette, B	Positive for pneumoconiosis, profusion category 2/2, type q/r opacities.
(same)	DX 1	Dr. Hippensteel, B	Negative for pneumoconiosis, profusion category 0/1, type p/q opacities.
(same)	DX 1	Dr. Scott, BCR, B	Completely negative.
(same)	DX 1	Dr. Wheeler, BCR, B	Completely negative.
(same)	DX 1	Dr. McCluney, BCR, B	Negative for pneumoconiosis.
(same)	DX 1	Dr. Castle, B	Positive for pneumoconiosis, profusion category 1/0, type q/p opacities.
(same)	DX 1	Dr. Stewart	Positive for pneumoconiosis, profusion category 1/0, type q/p opacities.
Feb. 16, 1988	DX 1	Dr. Mathur, BCR, B	Positive for pneumoconiosis, profusion category 2/1, type p/s opacities.
(same)	DX 1	Dr. DePonte, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type q opacities.
Feb. 22, 1988	DX 1	Dr. Patel, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type s/p opacities.
(same)	DX 1	Dr. Hippensteel, B	Negative for pneumoconiosis, profusion category 0/1, type p/q opacities.
(same)	DX 1	Dr. Castle, B	Negative for pneumoconiosis, type 0/1 opacities, type q opacities.

<sup>24</sup>There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

<sup>25</sup>The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

<sup>26</sup>I have not included Dr. Bassham’s interpretation of moderate interstitial fibrosis because he specifically indicated that he was not evaluating the film for industrial pneumoconiosis.

(same)	DX 1	Dr. Wheeler, BCR, B	Completely negative.
(same)	DX	Dr. Scott, BCR, B	Completely negative.
Mar. 1, 1988	DX 1	Dr. Westerfield, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type q/t opacities.
(same)	DX 1	Dr. McCluney, BCR, B	Negative for pneumoconiosis.
(same)	DX 1	Dr. Scott, BCR, B	Completely negative.
(same)	DX 1	Dr. Wheeler, BCR, B	Completely negative.
(same)	DX 1	Dr. Castle, B	Positive for pneumoconiosis, profusion category 1/0, type q/p opacities.
(same)	DX 1	Dr. Stewart	Positive for pneumoconiosis, profusion category 1/0, type p/q opacities.
(same)	DX 1	Dr. Hippensteel, B	Positive for pneumoconiosis, profusion category 1/0, type p/q opacities.
Oct. 17, 1988	DX 1	Dr. Sargent, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type q/p opacities.
(same)	DX 1	Dr. King, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type q opacities.
(same)	DX 1	Dr. Patterson, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type p/q opacities.
Oct. 29, 1988	DX 1	Dr. Fowler	(Negative for pneumoconiosis) <sup>27</sup> Mild interstitial markings, no active disease.
Nov. 7, 1988	DX 1	Dr. Bassali, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type q/t opacities.
Nov. 9, 1988	DX 1	Dr. Westerfield, BCR, B	Completely negative.
(same)	DX 1	Dr. Levy, BCR, B	Completely negative
(same)	DX 1	Dr. King, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type q/p opacities.
(same)	DX 1	Dr. Patterson, BCR, B	Completely negative.
(same)	DX 1	Dr. Westerfield, BCR, B	Completely negative.
Feb. 7, 1994	DX 1	Dr. Pendergrass, BCR, B	Negative for pneumoconiosis; profusion category 0/1, type s opacities.
(same)	DX 1	Dr. Wheeler, BCR, B	Completely negative.
(same)	DX 1	Dr. Scott, BCR, B	Completely negative.
Oct. 25, 1994	DX 1	Dr. Shahan, BCR	Completely negative.
(same)	DX 1	Dr. E. Sargent, BCR, B	Negative for pneumoconiosis.
(same)	DX 1	Dr. Spitz, BCR, B	Completely negative.
(same)	DX 1	Dr. Wiot, BCR, B	Completely negative

<sup>27</sup>Since a physician evaluating a chest x-ray can be expected to accurately report the presence of any abnormalities, an administrative law judge may infer that the absence of a mention of pneumoconiosis indicates pneumoconiosis was not present. See *Marra v. Consolidation Coal Co.* 7 BLR 1-216, 1-219 (1985).

Oct. 17, 1995	DX 1	Dr. Castle, B	Negative for pneumoconiosis, profusion category 0/1, type p/s opacities.
(same)	DX 1	Dr. Scott, BCR, B	Completely negative
(same)	DX 1	Dr. Wheeler, BCR, B	Completely negative
(same)	DX 1	Dr. Spitz, BCR, B	Completely negative.
Feb. 4, 1999	DX 2	Dr. S. Navani, BCR, B	Completely negative.
(same)	DX 2	Dr. Forehand, B	Completely negative
Aug. 21, 2001	DX 3	Dr. Patel, BCR, B	Positive for pneumoconiosis, profusion category 1/2, type p/q opacities.
(same)	DX 3	Dr. Wheeler, BCR, B	Negative for pneumoconiosis. Fibrosis/infiltrate present consistent with unknown TB (tuberculosis).
Mar. 4, 2002	DX 3	Dr. Halbert	Positive for pneumoconiosis, profusion category 1/1, type q opacities.
Mar. 18, 2002	DX 3	Dr. Cappiello, BCR, B	Positive for pneumoconiosis, profusion category 2/2, type p/q opacities.
Jul. 1, 2003	DX 15	Dr. Patel, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type t opacities.
(same)	DX 34	Dr. Scott, BCR, B	Negative for pneumoconiosis; calcified granuloma present.
Jun. 23, 2004	EX 7	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; “few tiny peripheral nodules and linear scars” present.
Feb. 4, 2005	CX 1	Dr. DePonte, BCR, B	Positive for pneumoconiosis, profusion category 1/0, category s/p opacities.
(same)	EX 12	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; granulomatous disease present.

Of the twenty-one chest x-rays, there is no dispute regarding thirteen of the films. Based on unopposed interpretations, the following four chest x-rays are positive for pneumoconiosis: October 4, 1985, November 7, 1988, March 4, 2002, and March 18, 2002. Likewise, also due to the absence of any disagreement, the following nine films are negative for the presence of pneumoconiosis: November 26, 1986, October 17, 1988, October 29, 1988, November 9, 1988, February 7, 1994, October 25, 1994, October 17, 1995, February 4, 1999, and June 23, 2004.

The physicians who examined the remaining eight chest x-rays reached contrary conclusions. In the March 19, 1973 chest x-ray, Dr. Sutter observed pneumoconiosis; Dr. Pendergrass, Dr. Wiot, and Dr. Wheeler did not. The consensus of the later three physicians establishes this film as negative for pneumoconiosis.

Dr. Robinette and Dr. Dr. Castle, both B readers, and Dr. Stewart considered the July 30, 1987 film positive for pneumoconiosis. However, Dr. Scott, Dr. Wheeler, and Dr. McClunery, who are dual qualified radiologists, and Dr. Hippensteel, a B reader, did not find black lung disease. Since Dr. Scott, Dr. Wheeler and Dr. McClunery have superior credentials,<sup>28</sup> their

<sup>28</sup>The courts and Benefits Review Board have determined that it is proper to give greater probative weight to the interpretation of a dual qualified radiologist in comparison to a physician who is only a B reader. *Zeigler Coal Co.*

consensus is more probative than the preponderance of opinion among the B readers. As a result, I find the July 30, 1987 film is negative for pneumoconiosis.

When two similarly qualified physicians evaluated the February 16, 1988 chest x-ray, they reached opposite conclusions. Dr. Mathur saw pneumoconiosis; Dr. DePonte did not. Since the two doctors have the same credentials as board certified radiologists and B readers, their professional standoff renders the February 16, 1988 film inconclusive for the presence of pneumoconiosis.

In the February 22, 1988 chest x-ray, Dr. Patel, a dual qualified radiologist found pneumoconiosis. On the other hand, Dr. Wheeler and Dr. Scott, also dual qualified radiologists, and two other B readers, Dr. Hippensteel and Dr. Castle, considered the film to be negative. Based on the preponderance of opinion by the better qualified physicians, I conclude the February 22, 1988 chest x-ray is negative.

Four physicians, Dr. Westerfield (a dual qualified radiologist), Dr. Castle, Dr. Stewart, and Dr. Hippensteel diagnosed pneumoconiosis in the March 1, 1988 chest x-ray. Another three physicians, all dual qualified radiologists, Dr. McClunery, Dr. Wheeler, and Dr. Scott, disagreed and determined the chest x-ray was negative for pneumoconiosis. Again, based on the consensus of three of the four better qualified doctors, I consider this chest x-ray to be negative.

Finally, due to the difference of opinion between equally well qualified physicians, the chest x-rays of August 21, 2001 (Dr. Patel vs. Dr. Wheeler), July 1, 2003 (Dr. Patel vs. Dr. Scott), and February 4, 2005 (Dr. DePonte vs. Dr. Wheeler), these three radiographic studies are inconclusive for the presence of pneumoconiosis.

In summary, setting aside the four inconclusive chest films (February 16, 1988, August 21, 2001, July 1, 2003, and February 4, 2005), four studies (October 4, 1985, November 7, 1988, March 4, 2002, and March 18, 2002) are positive for pneumoconiosis. However, the remaining thirteen chest x-rays (March 19, 1973, November 26, 1986, July 30, 1987, February 22, 1988, March 1, 1988, October 17, 1988, October 29 1988, November 9, 1988, February 7, 1994, October 25, 1994, October 17, 1995 February 4, 1999, and June 23, 2004) are negative for black lung disease. Consequently, the preponderance of the chest x-ray evidence is negative and Mr. Yates is unable to establish the presence of pneumoconiosis in his lungs by radiographic evidence under 20 C.F.R. § 718.202 (a) (1).

#### *Medical Opinion*

Although Mr. Yates cannot establish the presence of black lung disease through chest x-ray evidence, he may still prove this requisite element of entitlement under 20 C.F.R. § 718.202 (a) (4) through the preponderance of the more probative medical opinion. To better evaluate the diverse medical opinion, a review of the other objective medical evidence in the record is helpful.

---

*v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) and *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

## Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV <sub>1</sub> pre <sup>29</sup> post <sup>30</sup>	FVC pre post	MVV pre post	% FEV <sub>1</sub> / FVC pre post	Qualified <sup>31</sup> pre post	Comments
DX 1	Oct. 4, 1985 Dr. Modi	41 69"	3.62	4.45	110	81%	No	
DX 1	Nov. 26, 1986 Dr. Paranthaman	42 <sup>32</sup> 68"	3.67	4.53	120	81%	No	
DX 1	Jul. 30, 1987 Dr. Robinette	43 68"	3.69	4.56	114	81%	No	
DX 1	Feb. 22, 1988 Dr. Baxter	44 69"	3.55	4.52	118	79%	No	
DX 1	Oct. 17, 1988 Dr. Sargent	44 69"	2.69 3.13	3.89 4.40	79 69	69% 71%	No No	
DX 1	Nov. 9, 1988 Dr. Smiddy	44 69"	2.47 3.33	3.37 4.16	56	73% 80%	No No	
DX 1	Oct 25, 1994 Dr. Forehand	50 68"	3.30	4.37	83	76%	No	
DX 1	Oct. 17, 1995 Dr. Castle	51 67"	3.26 3.46	4.11 4.26	99 109	79% 81%	No No	
DX 2	Feb. 4, 1999 Dr. Iosif	55 68"	3.18 3.33	4.56 4.59		70% 72%	No No	Mild obstruction
DX 3	Aug. 21, 2001 Dr. Rasmussen	57 68"	3.53	4.99	100	71%	No	
DX 3	Mar. 4, 2002 Dr. Rosenberg	58 69"	3.01	4.31	66	70%	No	
EX 9	Sep. 4, 2002 Dr. Forehand	58 67"	2.89 2.80	4.17 4.31	89 88	69% 65%	No No	
EX 10	Oct. 10, 2002 Dr. Forehand	58 67"	3.28	4.06		81%	No	
EX 11	Mar. 3, 2003 Dr. Forehand	59 69"	2.59	3.35		77%	No	
DX 14	Jul. 1, 2003 Dr. Rasmussen	59 68"	3.19	4.44	80	72%	No	
EX 7	Jun. 23, 2004 Dr. Castle	60 68"	2.61 3.02	3.50 4.10	89 88	74% 74%	No No	
CX 1	Feb. 4, 2005 Dr. Forehand	61 68"	3.74	4.97	95	75%	No	

<sup>29</sup>Test result before administration of a bronchodilator.

<sup>30</sup>Test result following administration of a bronchodilator.

<sup>31</sup>Under 20 C.F.R. § 718.204 (b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV<sub>1</sub> must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV<sub>1</sub>/FVC has to be equal to or less than 55%.

<sup>32</sup>The test result incorrectly indicates Mr. Yates' age as 45.

### Additional Arterial Blood Gas Studies<sup>33</sup>

Exhibit	Date / Doctor	pCO <sub>2</sub> (rest) pCO <sub>2</sub> (exercise)	pO <sub>2</sub> (rest) pO <sub>2</sub> (exercise)	Qualified	Comments
DX 1	Oct. 4, 1985 Dr. Modi	39.4	73.8	No	
DX 1	Nov. 26, 1986 Dr. Paranthaman	35.1 32.2	67.2 791.	No No	Mild resting hypoxemia
DX 1	Jul. 30, 1987 Dr. Robinette	34.5	78	No No	
DX 1	Feb. 22, 1988 Dr. Baxter	36	92	No	
DX 1	Oct. 17, 1988 Dr. Sargent	35.5	65.3	No	
DX 1	Nov. 9, 1988 Dr. Smiddy	35.4	72	No	
DX 1	Oct 25, 1994 Dr. Forehand	36 34	72 70	No No	
DX 1	Oct. 17, 1995 Dr. Castle	35.1	75.8	No	
DX 2	Feb. 4, 1999 Dr. Iosif	36.1	67.3	No	
DX 3	Aug. 21, 2001 Dr. Rasmussen	37 33	69 63	No Yes	
DX 3	Mar. 4, 2002 Dr. Rosenberg	36.4 35.7	69.9 75.8	No No	

#### Dr. S. K. Paranthaman (DX 1)

On November 26, 1986, Dr. Paranthaman conducted a pulmonary evaluation of Mr. Yates, who was still working as a coal miner. Though Mr. Yates may have been in the early stages of coal workers' pneumoconiosis, the chest x-ray did not sufficiently establish the presence of pneumoconiosis. The arterial blood gas study showed mild resting hypoxemia that improved with exercise. Otherwise, the pulmonary examination was normal.

#### Dr. Emory Robinette (DX 1)

On July 30, 1987, Dr. Robinette evaluated Mr. Yates' pulmonary condition. A 24 year coal miner, Mr. Yates reported recurrent smothering. He had smoked cigarettes for 20 years at the rate of a pack to a pack and a half a day. The physical examination revealed diminished breath sounds. The chest x-ray was positive for pneumoconiosis. The other breathing tests were normal. Dr. Robinette diagnosed coal workers' pneumoconiosis. At the same time, Mr. Yates retained normal pulmonary capabilities.

---

<sup>33</sup>The arterial blood gas studies obtained from 2003 to 2005 have already been summarized and established a change in condition.



Dr. Robert F. Baxter  
(DX 1)

On February 2, 1988, Dr. Baxter, board certified in family practice, examined Mr. Yates. Mr. Yates had 26 years of coal mine employment and reported periodic shortness of breath. Upon physical examination, Dr. Baxter heard coarse rhonchi, bilaterally. The chest x-ray was positive for pneumoconiosis. However, other testing did not establish any impairment. Dr. Robinette diagnosed COPD (chronic obstructive pulmonary disease) with coal workers' pneumoconiosis.

Dr. Dale Sargent  
(DX 1)

On October 17, 1988, Dr. Sargent, board certified in pulmonary disease and internal medicine, conducted a pulmonary evaluation. Mr. Yates had 23 years of coal mine employment. His cigarette smoking history spanned 18 years at half a pack a day. The physical examination of the chest was normal. The pulmonary testing was near normal and the chest x-ray was negative. Dr. Sargent concluded Mr. Yates did not have coal workers' pneumoconiosis. He diagnosed mild, and reversible, obstructive pulmonary impairment associated with cigarette abuse and mild asthma.

Dr. Joseph F. Smiddy  
(DX 1)

On November 9, 1988, Dr. Smiddy evaluated Mr. Yates. Mr. Yates' complaints included shortness of breath and weakness. He had worked in the coal mines for 24 years and smoked cigarettes for 8 years at half a pack a day. Upon physical examination, Dr. Smiddy heard scattered rhonchi and wheezes. The chest x-ray was normal. The arterial blood gas was borderline for hypoxemia. Similarly, the pulmonary function test showed a borderline obstruction. Dr. Smiddy concluded Mr. Yates was totally disabled due to both cigarette smoking and pneumoconiosis, even though the chest x-ray did not show its presence.

Dr. Gregory J. Endres-Bercher  
(DX 1)

During a November 1988 evaluation of Mr. Yates for arthritic complaints, Dr. Endres-Bercher, board certified in internal medicine, noted that his lungs were clear and the chest x-ray did not show any evidence of active pulmonary disease.

Dr. Virginia A. Baluyot  
(DX 1)

During a disability examination in October 1989, Dr. Baluyot noted Mr. Yates' complaints of smothering. He also indicated that Mr. Yates smoked up to two packs of cigarettes a day. He had also worked in the coal mines for 27 years. The chest examination was normal.

Dr. German Iosif  
(DX 2)

On February 4, 1999, Dr. Iosif, board certified in pulmonary disease and internal medicine, examined Mr. Yates, who had mined coal for 28 years. For the last ten years, Mr. Yates struggled with exertional shortness of breath. He had smoked cigarettes since the age of 18 at the rate of one pack per day through 1995. Currently, Mr. Yates smoked a pipe. In February 1994, Mr. Yates had an acute myocardial infarction and angioplasty. The physical examination and arterial blood gas study were normal. The chest x-ray was completely negative. The pulmonary function tests indicated the presence of a "very mild" and "insignificant" pulmonary obstruction related to cigarette smoking. Dr. Iosif opined Mr. Yates did not have an occupational lung disease.

Dr. D. L. Rasmussen  
(DX 3 and DX 11)

On August 21, 2001, Dr. Rasmussen, board certified in internal medicine, evaluated Mr. Yates. Mr. Yates had 31 years of coal mine employment. In his last mining job as a jack setter, Mr. Yates had to lift heavy rock dust bags. He had been a pack a day cigarette smoker since 1961. Upon physical examination, Dr. Rasmussen noted minimally reduced breath sounds. The chest x-ray was positive for pneumoconiosis. The pulmonary function test was normal. The arterial blood gas study showed a marked and totally disabling reduction in oxygenation upon exercise. Dr. Rasmussen diagnosed coal workers pneumoconiosis based on Mr. Yates' 31 years of coal mine employment and his chest x-ray. The physician also believed Mr. Yates had chronic bronchitis attributable to both coal dust exposure and cigarette smoke. Based on the exercise blood gas test, Dr. Rasmussen concluded Mr. Yates was unable to return to coal mining. Since Mr. Yates' respiratory impairment involved a significant reduction in the loss of oxygen transfer capability in the absence of any ventilatory deficiency, Dr. Rasmussen indicated Mr. Yates' totally disabling respiratory impairment was more consistent with damage caused by coal dust exposure. At the same time, both coal dust and cigarette smoke contributed to his impairment.

On July 1, 2003, Dr. Rasmussen conducted a second pulmonary examination. Mr. Yates continued to complain about shortness of breath for the past twelve years. Mr. Yates had undergone cardiac catheterization in 1994 and had a history of systemic hypertension. Upon examination, Dr. Rasmussen heard moderately reduced breath sounds. Mr. Yates' blood pressure was 140/80. The chest x-ray was positive for pneumoconiosis. The pulmonary function test was normal. The arterial blood gas studies revealed marked impairment of oxygen transfer during light exercise. Dr. Rasmussen diagnosed coal workers' pneumoconiosis based on the positive chest x-ray and Mr. Yates' 29 years of coal mine employment. The arterial blood gas test results established that he was totally disabled and did not retain the respiratory capacity to return to coal mining. During the exercise test, Mr. Yates' blood pressure elevated to 160/115. Both cigarette smoke and coal dust contributed to the impairment. At the same time, Dr. Rasmussen opined that coal dust was the major cause due to the "finding of marked impairment in oxygen transfer during exercise absent loss of ventilatory capacity."

Dr. David M. Rosenberg  
(DX 3)

On March 4, 2002, Dr. Rosenberg, board certified in pulmonary disease, internal medicine, and occupational medicine, evaluated Mr. Yates who complained about chronic and long-term shortness of breath. Mr. Yates had mined coal for 31 years; his last job as a jack setter involved heavy labor. Mr. Yates had smoked cigarettes for over 30 years at one pack per day; he stopped in 1997. He had no history of asthma or tuberculosis. The physical examination was normal and the pulmonary function test was essentially normal. The arterial blood gas study showed appropriate rising oxygenation upon exercise. The chest x-ray was positive for pneumoconiosis. Dr. Rosenberg diagnosed simple coal workers' pneumoconiosis. However, Mr. Yates did not have a disabling pulmonary or respiratory impairment.

Dr. Denny L. Gash  
(DX 39)

On August 22, 2003, under Dr. Gash's supervision, Mr. Yates underwent a stress test to evaluate progressively worsening shortness of breath. Except for PVCs (premature ventricular contractions), the test results were normal.

On August 29, 2003, Dr. Gash, board certified in cardiovascular disease and internal medicine,<sup>34</sup> conducted a cardiac examination. Mr. Yates' medical history included COPD (chronic obstructive pulmonary disease) and coal workers' pneumoconiosis. Two weeks earlier, Mr. Yates experienced aggravated shortness of breath while working in the yard and was treated in the emergency room. Mr. Yates had been a coal miner for 29 years. His cigarette smoking history was 30 pack years.<sup>35</sup> Upon physical examination, Dr. Gash noted diminished lung bases. In light of the normal stress test, Dr. Gash concluded the "primary cause of his dyspnea is pulmonary dysfunction." Nevertheless, Dr. Gash also indicated that Mr. Yates would wear a heart monitor for a month. Dr. Gash diagnosed COPD with progressive dyspnea.

On September 26, 2003, Dr. Gash reported the heart monitor showed "sinus rhythm with unifocal PVCs."

Dr. James R. Castle  
(DX 1, EX 7, EX 8, and EX 13)

On October 17, 1995, Dr. Castle, board certified in pulmonary disease and internal medicine, evaluated Mr. Yates' pulmonary condition. Mr. Yates reported persistent breathing problems. He had been a coal miner for over 27 years and last worked as a roof bolter. From the age of 17 until about 1989, Mr. Yates smoked a pack and a half of cigarettes a day; upon a doctor's advice, he cut back to half a pack a day. According to Dr. Castle, Mr. Yates' cigarette

---

<sup>34</sup>As I advised the parties at the hearing (TR, pages 6-7), I take judicial notice of Dr. Gash's board certification and have attached the certification documentation..

<sup>35</sup>A pack year equals the consumption of one pack of cigarettes per day for one year.

smoking history equaled 45 pack years. In 1993, Mr. Yates suffered a myocardial infarction and underwent cardiac catheterization. The physical examination, arterial blood gas study, and pulmonary function tests were normal.<sup>36</sup> Although the chest x-ray contained a few opacities, Dr. Castle found their profusion insufficient to diagnose pneumoconiosis.<sup>37</sup> Based on his examination, Dr. Castle opined Mr. Yates did not have coal workers' pneumoconiosis or a pulmonary impairment. Instead, he diagnosed coronary artery disease and angina pectoris. Dr. Castle also reviewed the extensive radiographic and medical record and reached the same conclusions.

On June 23, 2004, Dr. Castle conducted a pulmonary examination. Mr. Yates reported having chest pains associated with shortness of breath for several years. A recent stress test was "ok." Mr. Yates had 27 years of coal mine employment and he last worked as a roof bolter. His cigarette smoking history was 34 pack years. The physical examination was normal. The chest x-ray did not reveal the presence of pneumoconiosis. The pulmonary function test was normal with "very significant improvement" to bronchodilator therapy. The EKG was abnormal and the resting blood gas study was normal. Based on his examination, Dr. Castle concluded Mr. Yates did not have coal workers pneumoconiosis. Although the pulmonary function tests showed a mild reversible airways obstruction consistent with bronchial asthma, Mr. Yates was not totally disabled.

On June 23, 2004, Dr. Castle also reviewed Mr. Yates' medical and radiographic record, including past several pulmonary examinations and Dr. Gash's cardiac evaluation. Dr. Castle continued to opine that Mr. Yates did not have coal workers' pneumoconiosis. According to Dr. Castle, Mr. Yates faced four pulmonary risk factors: coal dust exposure, cigarette smoke exposure, cardiac issues, and obesity. He eliminated coal dust as a possible cause for several reasons. First, the radiographic evidence was predominately negative for the presence of pneumoconiosis. Second, on physical examination, Mr. Yates did not have the rales, crackles, and crepitation associated with pneumoconiosis. Third, Mr. Yates' pulmonary obstruction was variable. Fourth, likewise the arterial blood gas studies which were normal at rest and at times normal with exercise indicated a "variable degree of oxygenation over time." Such variability is "not indicative of hypoxemia caused by coal mine induced lung disease." Consequently, Mr. Yates' breathing problems are more likely due to cardiovascular disease and hypertension. Dr. Castle again opined Mr. Yates does not have pulmonary total disability. Instead, Mr. Yates is totally disabled by cardiovascular disease unrelated to coal mine dust.

In a November 30, 2004 deposition, Dr. Castle reviewed his pulmonary evaluation of Mr. Yates. He noted that Mr. Yates' presenting symptoms, including a complaint of recent chest pain while working in the yard, correlated with angina pectoris related to cardiac disease. Although Mr. Yates' breath and cardiac sounds were normal, the EKG was "distinctly abnormal" indicating the possibility of ischemia, or inadequate blood supply to the heart, which is indicative

---

<sup>36</sup>The carboxyhemoglobin level was consistent with a pack a day cigarette smoker.

<sup>37</sup>Dr. Castle acknowledged that he had interpreted an earlier chest x-ray as positive for pneumoconiosis. He explained that the film quality for the earlier film was not as good as the chest x-ray associated with his October 1995 examination. Based on that better film quality, Dr. Castle believed the profusion was insufficient to establish pneumoconiosis.

of coronary artery disease. That heart disease is unrelated to coal dust exposure. On the other hand, cigarette smoking is a risk factor for the development of atherosclerotic heart disease and hypertension. He acknowledged that the 2003 stress test “did not show ischemia or a previous myocardial infarction.” Nevertheless, Mr. Yates did suffer a myocardial infarction that lead to angioplasty and was “clearly due to atherosclerotic heart disease.” Further, the EKGs consistently showed changes consistent with ischemia. Dr. Castle found no evidence of coal workers’ pneumoconiosis or a totally disabling respiratory impairment. Although he had previously interpreted a chest x-ray positive for pneumoconiosis, Dr. Castle believed the earlier reading may have been caused by poor film quality. The most recent chest x-ray was clearly negative. Mr. Yates is totally disabled due to cardiac disease. Even if coal workers’ pneumoconiosis were present, Mr. Yates does not suffer any respiratory impairment due to coal dust exposure.

Concerning the recent exercise blood gas tests, such as Dr. Rasmussen’s 2003 evaluation showing total disability, Dr. Castle first noted Dr. Rosenberg obtained a normal exercise arterial blood gas study in 2002 indicating variability in the exercise tests. Then, he emphasized that during the abnormal 2003 exercise test with Dr. Rasmussen, Mr. Yates’ recorded blood pressure was 160/115, well above the normal threshold of 120/80. In particular, the bottom number, the diastolic reading of 115 was particularly significant. According to Dr. Castle,

[This] diastolic dysfunction . . . means that there is a stiffness in the left ventricle and when that is present, it impedes the heart from filling appropriately and the pressure builds up. When the pressure builds up, particularly during diastole, which is shortened during exercise, it can lead to increased congestion, which will cause a fall in PO<sub>2</sub>. At that time, in the presence of this very significant degree of hypertension, he had a fall in PO<sub>2</sub>. On other occasions, when this has not been present, the fall in PO<sub>2</sub> did not occur. I think that the finding of his abnormal electrocardiogram, his symptoms, the hypertensive response to exercise, and the fall in PO<sub>2</sub> all go hand in hand, that’s the reason for that. The other factor that would make me believe this is the intermittent nature of it. I think that this man can have periodically some evidence of resting hypoxemia based on ventilation perfusion mismatching related to his underlying tobacco smoke induced mild pulmonary emphysema.

In April 2005, Dr. Castle reviewed the two most recent chest x-ray interpretations by Dr. Wheeler and Dr. DePointe and the February 2005 pulmonary evaluation by Dr. Forehand. This additional medical evidence did not cause Dr. Castle to change his opinions about the absence of pneumoconiosis and a totally disabling respiratory impairment. He noted that at the time of Dr. Forehand’s examination, Mr. Yates’ blood pressure was 147/92, which is abnormal. Since Dr. Forehand did not apparently monitor Mr. Yates’ blood pressure during the exercise blood gas test, Dr. Castle was unable to ascertain whether the disabling result was due to hypertension.

Dr. J. Randolph Forehand  
(DX 1 and CX 1)

On October 25, 1994, Dr. Forehand, board certified in allergy and pediatrics, examined Mr. Yates, who reported 20 years of coal mine employment. Mr. Yates had also smoked cigarettes since 1974 (20 years) at the rate of a pack a day. He complained about dyspnea with activity and smothering. The physical examination and pulmonary function tests were normal. The chest x-ray was clear. The arterial blood gas indicated no hypoxemia at rest. Dr. Forehand concluded there was no evidence of an active pulmonary disease or respiratory impairment.

On February 4, 2005, Dr. Forehand examined Mr. Yates, who had experienced shortness of breath for 15 years. Mr. Yates had worked as a coal miner for 29 years and smoked cigarettes for 37 years at the rate of half a pack a day. According to Dr. Forehand, Mr. Yates “denies known coronary artery disease.” No hospitalization or surgery was reported. A 2002 cardiac workup was unremarkable. Dr. Forehand heard inspiration crackles upon physical examination. Mr. Yates’ blood pressure was 147/92. The EKG was normal.<sup>38</sup> The chest x-ray was positive for pneumoconiosis. The pulmonary function test was normal. The arterial blood gas study showed an “abnormal response to exercise” and was “indicative of exercise-induced arterial hypoxemia.” In light of the blood gas studies, Mr. Yates was totally disabled and could not return to coal mining. Though sedentary lifestyle and cigarette smoking could have contributed to the impairment, Dr. Forehand attributed Mr. Yates’ totally disabling impairment to coal workers’ pneumoconiosis and his exposure to coal dust. The physician noted that while cigarette smoking causes a pulmonary obstruction and produces emphysematous changes in the lungs, Mr. Yates’ pulmonary function test was normal and his x-ray did not indicate emphysema. Dr. Forehand concluded:

If one analyzes the pattern of Mr. Yates’ respiratory impairment (normal ventilation function with abnormal oxygenation) along with risk factors, the most likely and medically reasonable diagnosis is coal workers’ pneumoconiosis. There is no history of arthritis, pulmonary infections, emphysema or other cigarette-related disease lung disease to explain Mr. Yates’ findings.

Discussion

Over the course of nearly 20 years, thirteen physicians have conducted numerous evaluations and reached varying conclusions about Mr. Yates’ pulmonary condition. Dr. Robinette, Dr. Baxter, Dr. Smiddy, Dr. Rosenberg, Dr. Rasmussen, and Dr. Forehand concluded Mr. Yates had coal workers’ pneumoconiosis. Dr. Paranthaman, Dr. Sargent, Dr. Endres-Bercher, Dr. Baluyot, Dr. Iosif, and Dr. Castle did not find evidence of black lung disease. Due to this conflict in medical opinion, I must first assess the relative probative value of each respective opinion in terms of documentation, reasoning, medical qualifications, and the impact of inadmissible evidence under the regulatory evidentiary restrictions.

Regarding the first probative value consideration, documentation, a physician’s medical opinion is likely to be more comprehensive and probative if it is based on extensive objective

---

<sup>38</sup>The EKG computer printout states, “normal sinus rhythm; nonspecific ST & T wave abnormality; abnormal ECG.”

medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

Third, a physician who is board-certified in the field of pulmonary disease and who has extensive experience in this area may be accorded greater deference because of his or her expertise. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc); *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Burns v. Director, OWCP*, 7 BLR 1-597 (1984).

Fourth, as previously mentioned in the initial evidentiary discussion, I must also assess the probative value of medical opinion that considered evidence that was not admissible due to the restrictions in 20 C.F.R. § 725.309 and 20 C.F.R. §§ 725.414 (a) (2) (i) and 3 (i).

With these principles in mind, I first find the assessments of Dr. Endres-Bercher, Dr. Baluyot, and Dr. Gash have limited probative value on the issue of whether Mr. Yates has pneumoconiosis due to the narrow nature of their inquiries which diminished the documentary basis of their evaluations. In particular, Dr. Endres-Bercher was focused on Mr. Yates' arthritis, Dr. Gash concentrated on cardiac issues, and Dr. Baluyot assessed overall disability. Consequently, these doctors conducted limited pulmonary examinations without any apparent accompanying pulmonary tests.

Next, while the assessments of Dr. Paranthaman, Dr. Sargent, Dr. Iosif, Dr. Robinette, Dr. Baxter, and Dr. Smiddy rest on firm documentary basis, their assessments nevertheless have limited probative value on the present state of Mr. Yates' pulmonary condition in light of the recent development of a totally disabling oxygenation problem during exercise. None of these physicians were aware of that development and consequently did not address its impact on their respective diagnoses.

I also note that the findings of pneumoconiosis by Dr. Robinette, Dr. Baxter, and Dr. Smiddy also suffer loss of probative value due to reasoning shortfalls. Dr. Robinette and Dr. Baxter diagnosed medical pneumoconiosis based on positive chest x-ray interpretations. However, I have concluded that the preponderance of the chest x-ray evidence is negative for pneumoconiosis. Consequently, their medical pneumoconiosis findings rely on incorrect documentation. Next, acknowledging the absence of radiographic evidence of pneumoconiosis, Dr. Smiddy nevertheless concluded Mr. Yates had a pulmonary impairment due to

pneumoconiosis. However, since Dr. Smiddy did not state the specific details from his pulmonary examination that support his diagnosis of legal pneumoconiosis, his conclusion is not well reasoned.

In a manner similar to Dr. Robinette and Dr. Baxter, the more recent finding by Dr. Rosenberg of simple coal workers' pneumoconiosis loses probative value because he principally relies on a positive chest x-ray interpretation; whereas, I have determined the preponderance of the radiographic evidence does not establish the presence of pneumoconiosis.

Although Dr. Forehand conducted a thorough pulmonary examination, his conclusion that Mr. Yates' oxygenation disability was caused by coal dust exposure (legal pneumoconiosis) has diminished probative value due to incomplete and inaccurate documentation and a reasoning problem. First, when he obtained Mr. Yates' medical history, Dr. Forehand noted that the Claimant denied any coronary artery disease and reported a normal 2002 cardiac work-up. As a result, Dr. Forehand had incomplete documentation about Mr. Yates' cardiac problem. He was not aware that Mr. Yates' medical history included a myocardial infarction and angioplasty. Understandably, when he addressed the possible cause of Mr. Yates' respiratory insufficiency, Dr. Forehand did not consider coronary artery disease attributable to cigarette abuse as a possible explanation. Second, although Dr. Forehand did not specifically diagnose clinical pneumoconiosis, he nevertheless believed the radiographic evidence was positive for pneumoconiosis, contrary to my evidentiary determination. Thus, part of the documentary basis that he may have relied upon was inaccurate. Third, in terms of reasoning and in light of Dr. Castle's presentation, Dr. Forehand did not address whether Mr. Yates' history of hypertension and his examination blood pressure of 147/92 may have contributed to the abnormal exercise blood gas study.

For reasons previously discussed, Dr. Rasmussen's diagnosis of clinical pneumoconiosis based on a positive chest x-ray and Mr. Yates' history of coal mine employment has diminished probative value since the preponderance of the radiographic evidence is negative rather than positive for pneumoconiosis.

Dr. Rasmussen's finding of legal pneumoconiosis also has diminished probative value due to incomplete documentation and insufficient reasoning associated with his identification of two, rather than three, risk factors for Mr. Yates' oxygenation insufficiency. Documentation-wise, because he only considered the results of his 2001 and 2003 pulmonary examination, Dr. Rasmussen was not aware that in-between those two evaluations, Dr. Rosenberg obtained a normal exercise blood gas test result. Absent that documentation, Dr. Rasmussen was not in a position to address how the demonstrated variability was consistent with the permanent lung damage caused by coal workers' pneumoconiosis. On the issue of reasoning, based on Mr. Yates' cigarette smoking and coal mine employment histories, Dr. Rasmussen reasonably considered cigarette smoke and coal dust as possible contributing factors to his respiratory impairment. However, Dr. Rasmussen failed to completely integrate and address all the medical evidence before him. Unlike Dr. Forehand, Dr. Rasmussen was well aware of Mr. Yates' cardiac medical history, chronic hypertension, and chest pain complaints. Additionally, during his 2003 examination of Mr. Yates, the EKG ST-T waves showed changes and Mr. Yates' blood pressure during the exercise blood gas reached 160/115. In identifying coal dust as the major contributing



factor, Dr. Rasmussen seemingly ignored this possibly related cardiac documentation. In particular, due to the abnormal blood pressure during exercise, Dr. Rasmussen did not address whether a hypertensive response rather than coal dust lung damage might explain the abnormal blood gas test result.

In terms of documentation, Dr. Castle was the only physician to consider the entire medical record through the most recent examinations. Ordinarily, having the best documentary basis for rendering a medical opinion would be a good thing. However, under the new regulatory-imposed evidentiary restrictions, Dr. Castle's thoroughness carried a significant risk of running afoul of those restrictions and he did. Specifically, Dr. Castle relied on some inadmissible evidence under the regulations by providing his own negative interpretation of the chest x-ray associated with his 2004 pulmonary examination and reviewing two recent inadmissible pulmonary examinations by Dr. Rasmussen (January 2004) and Dr. Rosenberg (November 2003). As a remedy, I have not considered Dr. Castle's radiographic interpretation. Additionally, his "mistake" of interpreting the film has little prejudicial effect since Dr. Castle also summarized Dr. Wheeler's admitted interpretation of the same chest x-ray and Dr. Wheeler's interpretation was also negative. I also conclude that Dr. Castle's consideration of the two inadmissible pulmonary examinations has little adverse impact on the probative value of his opinion because Dr. Rasmussen and Dr. Rosenberg reached contrary conclusions and the results of their two inadmissible examinations remarkably parallel the other two admissible examinations by the same physicians, Dr. Rasmussen's July 2003 pulmonary evaluation and Dr. Rosenberg's March 2002 pulmonary evaluation. Additionally, Dr. Castle stressed the pattern of the arterial blood gas studies, rather than the sheer number of test results. Consequently, I find little reason to diminish the probative value of his analysis due to his breaches of regulatory evidence boundaries.

As noted above, Dr. Castle provided the best documented medical opinion and he considered multiple pulmonary risk factors in analysis the cause of Mr. Yates' inability to fully oxygenate his blood. His conclusion that Mr. Yates' respiratory impairment is due to a hypertensive response rather than coal dust exposure is generally well reasoned and integrates all the radiographic evidence, cardiac medical history including a myocardial infarction and angioplasty, presenting symptoms, 2004 abnormal EKG results, pulmonary examination test results, variability in exercise arterial blood gas test results, and demonstrated high blood pressure.

At the same time, Dr. Castle's opinion still suffers some probative loss due to a reasoning issue related to analysis of a cardiac stress test. Just a year before Dr. Castle examined Mr. Yates in 2004, Dr. Gash, a cardiologist, conducted a cardiac stress test and heart monitoring which only revealed PVCs. While recognizing that the stress test produced near-normal results, Dr. Castle stressed that Mr. Yates' myocardial infarction episode and angioplasty were still indicative of coronary artery disease. That response is insufficient because Mr. Yates suffered the myocardial infarction ten years before the stress test. In other words, while Mr. Yates had a medical history which included a myocardial infarction, as of the date of Mr. Yates' 2003 stress test, his heart did not appear to be imposing any cardiac limitations.<sup>39</sup> I acknowledge that the

---

<sup>39</sup>Dr. Gash's test results may explain Mr. Yates' 2005 presentation to Dr. Forehand that he did not have coronary artery disease.

cardiac stress test and the exercise arterial blood gas study may not be identical types of tests and Dr. Castle obtained an abnormal EKG indicating ischemia a year later. Nevertheless, this reasoning concern prevents my concluding that Dr. Castle's opinion is the most definitive assessment in the record concerning the cause of Mr. Yates' oxygenation deficiency upon exercise.

In summary, no probative medical opinion exists to establish the presence of clinical pneumoconiosis. Concerning legal pneumoconiosis, for diverse reasons, some greater than others, all the medical opinions in the record have diminished and insufficient probative value to the extent that no medical opinion sufficiently establishes whether Mr. Yates' respiratory impairment is due to his long term exposure to coal dust. Since Mr. Yates bears the burden of proof in this case, this ultimate dearth of probative medical opinion supporting a finding of pneumoconiosis means he is unable to prove by the preponderance of probative medical opinion the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a) (4).

#### *Compton Analysis*

Under the guidance of the decision in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), I must also consider both the chest x-ray evidence and medical opinion together to determine whether Mr. Yates has pneumoconiosis. In that regard, since standing alone neither the preponderance of the chest x-rays nor the medical opinion established the presence of pneumoconiosis, consideration of that evidence together obviously still fails to produce a finding of pneumoconiosis.

#### **CONCLUSION**

Based on the most recent exercise arterial blood gas studies which met the total disability standards, Mr. Yates has demonstrated a change in conditions which warrants modification of the denial of his fourth claim in May 2002 based the absence of a totally disabling respiratory impairment. That modification in turn establishes that a material change in his pulmonary condition has occurred since the denial of Mr. Yates third claim in 1999. However, upon consideration of the entire record, I find the preponderance of the radiographic evidence is negative for pneumoconiosis. Similarly, in the absence of a sufficiently probative medical assessment, Mr. Yates is unable to establish the presence of pneumoconiosis through medical opinion. Accordingly, having failed to prove the first requisite element of entitlement, the presence of pneumoconiosis, Mr. Yates' claim for black lung disability benefits must be denied.

## **ORDER**

The modification request by MR. JIMMY R. YATES is **DENIED**.

**SO ORDERED:**

**A**  
RICHARD T. STANSELL-GAMM  
Administrative Law Judge

Date Signed: May 11, 2006  
Washington, DC

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

**Attachment No. 1**

American Board of Medical Specialties

Certification:

Dr. Denny Lynn Gash

Certified by the American Board of Internal Medicine in:

Internal medicine and cardiovascular disease

American Board of Medical Specialties

1007 Church Street, Suite 404

Evanston, IL 60201-5913

Phone Verification: (866) ASK-ABMS

Phone: (847) 491-9091/FAX: (847) 328-3596

Copyright 2000, American Board of Medical Specialties

[HTTP://www.abms.org](http://www.abms.org)